

**MOURNESIDE**

**F A M I L Y P R A C T I C E**

*Dr James Gillespie*

*Dr Diane Robinson*

*Dr Heather Smyth*

*Dr Brian Gallagher*

*Dr Gareth Rankin*

*Dr Enda McSorley*

Thank you for your interest in Mourneside Family Practice.

We offer an appointment for a Health Check with a Practice Nurse to potential new patients.

A Patient Health Questionnaire is enclosed. Please complete what you can prior to seeing the nurse.

When you attend the Health Check appointment please bring:-

* A fresh specimen of urine (sample bottle enclosed);
* A completed Health Questionnaire
* Ensure details of current medication are recorded
* Ensure details of any family history are recorded
* Previous medical card(s)

If you are unable to attend the Health Check appointment please cancel at least 24 hours prior to your appointment so we can offer it to someone else.

If you fail to attend without notifying us we will remove you from our list.

If you are on numerous repeat medications you will be asked to make an appointment with a GP before being issued the repeat medication.

Please read the leaflet on “Missed Appointments”

If you care for someone please fill out the “**CARERS IDENTIFICATION AND REFERRAL FORM”**

**OUR PRACTICE CHARTER**

You will be treated as an individual, with courtesy and respect at all times.

We ask that you treat doctors and all practice staff with the same courtesy and respect.

We will try to answer the phone promptly and courteously. We ask you to try to telephone outside peak surgery times for non-urgent requests.

We will try to see you at your appointment time. Please do everything you can to keep appointments. Tell us as soon as possible if you cannot. If we are running behind please bear with us. You may, on occasion, need extra time.

We will visit you at home if you are too ill to visit the surgery.

Please do not request a home visit unless it is strictly necessary.

Such requests should reach the surgery before 10.00am (unless a genuine emergency arises later).

You will be seen outside normal surgery hours for emergencies – see details regarding Out Of Hours in the Practice leaflet.

Please do not telephone out-of-hours except in real cases of emergency.

We are striving to maintain accurate medical records and ask that you remember to tell us if you change your name, address, telephone number etc.

We have the right to remove patients from our list if they repeatedly and persistently ignore their responsibilities to us and other patients.

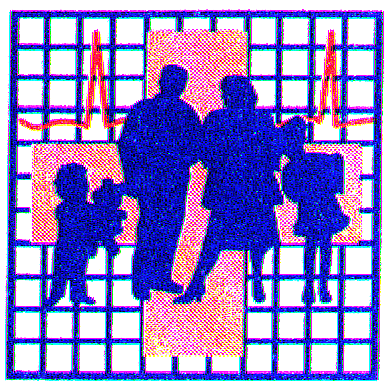
If you are seriously unhappy with us or the services we provide you have the right at any time to leave our list and register with another practice

**IDENTIFICATION REQUIRED FROM PATIENTS WISHING TO REGISTER WITH THE PRACTICE**

* **PATIENTS FROM WITHIN UK:**
  + **Copy of Passport**
  + **Utility Bill**
* **PATIENTS FROM EEA COUNTRIES:**
  + **Copy of Passport**
  + **European Health Insurance Card (EHIC)**
  + **Personal Identification Card (PIC)**
* **OTHER COUNTRIES:**
  + **Copy of Passport**

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**MISSED APPOINTMENTS**

Due to the number of patients failing to attend for their appointment this may mean that you may not be able to see the doctor on the day that you wish.

In an attempt to try and resolve this problem the practice has developed the following policy.

If you fail to attend for *2* consecutive appointments without informing us we will write to you asking if there are any specific problems preventing you from letting us know.

If you fail to attend for a 3rd appointment you may be removed from the practice list and have to find an alternative GP practice.

**CARERS IDENTIFICATION AND REFERRAL FORM**

**DO YOU LOOK AFTER SOMEONE WHO IS**

**ILL, FRAIL, DISABLED or MENTALLY ILL?**

If so, you are a carer and we would like to support you. Please complete this form and hand it in to reception.

If you are agreeable, we will pass your details to the Carers Service, which is a countywide organisation providing relevant information and advice, local support services, newsletter and telephone link line for carers.

**YOUR DETAILS:**

|  |  |
| --- | --- |
| Name |  |
| Date Of Birth |  |
| Address |  |
| Post Code |  |
| Telephone Number |  |
| Any relevant information |  |

**DETAILS OF THE PERSON YOU LOOK AFTER:**

|  |  |
| --- | --- |
| Name |  |
| Date Of Birth |  |
| Address  (If Different From Above) |  |
| Post Code |  |
| Telephone Number  (If Different From Above) |  |
| GP Details  (If Different From Your Own) |  |

□ Please pass my details to the Carers Service▫

***Thank you for completing this form***

**MOURNESIDE FAMILY PRACTICE**

**ADULT HEALTH QUESTIONNAIRE**

STATUS: M | S | D | W

OCCUPATION:

................................................

................................................

NAME:

ADDRESS: ...........................................................

....................................................................

POST CODE: ........................................................

DOB: ........................ TEL: ................................

PLEASE TICK RELEVANT BOX:

ALCOHOL:

TT

EX

MOD.

LIGHT

HEAVY

20+

9-20

NON

EX

1-9

SMOKING:

VIGOROUS

MOD

GENTLE

INACTIVE

EXERCISE:

NT

Y

SPECIAL DIET: TYPE................................ LAST SMEAR: .......................

NT

Y

ALLERGY: TYPE................................ RUBELLA IMMUNE................

TETANUS IMMUNE...............

YT

NT

MAMMOGRAM: DATE:.....................

PAST MEDICAL HISTORY:

COMMENTS

CONDITION

DATE

REGULAR MEDICATION:

N

Y

MEDICATION

DOSAGE

CONDITION

PERSONAL

HISTORY

FAMILY

HISTORY

RELATIONSHIP

BLOOD PRESSURE

HEART DISEASE

STROKE

ASTHMA

DIABETES

EPILEPSY

STOMACHPROBLEMS /ULCERS

ARTHRITIS

THYROID TROUBLE

MENTAL ILLNESS

YES/NO

YES/NO

YES/NO

YES/NO

YES/NO

YES/NO

YES/NO

YES/NO

YES/NO

YES/NO

YES/NO

YES/NO

YES/NO

YES/NO

YES/NO

YES/NO

YES/NO

YES/NO

YES/NO

YES/NO

**FOR DOCTOR’S USE**

DATE OF EXAMINATION

HEIGHT: WEIGHT:

BP: PEAK FLOW:

URINALYSIS GLUCOSE PROTEIN BLOOD OTHER

CONCERNS:

ADVICE: